(i) At the conclusion of the audit, the provider shall be afforded an opportunity to submit additional documentation to the commissioner. After the receipt and review of such additional documentation, a copy of the audit findings shall, within 120 days, be sent to the provider by certified mail, return receipt requested. In order to have the additional documentation considered, the provider must submit the documentation within the time specified.

(ii) The audit findings shall become final unless within 30 days of receipt thereof, the provider requests an administrative review of the audit findings.

(iii) Request for administrative review and audit findings shall be sent to the commissioner by registered or certified mail.

(iv) Such requests shall contain a detailed statement of the provider's objections to the findings, along with copies of any documentation the facility wishes to submit.

(v) The provider shall be notified in writing of the determination of those items to which the provider objected, including a statement of the reasons therefor. The audit findings, as adjusted in accordance with the determination after administrative review, shall be final.

(g) Effective [April 16, 1992] April 4, 1996, [the amount of the provider of service assessment included in the rate is equal to eighty percent of the total assessment amount] the rate shall include 5.4 percent of the base costs used to determine the costs associated with the 6 percent provider of services assessment, a tax imposed on providers of service in accordance with Public Law 102-234, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. The Medicaid reimbursed portion of the provider of service assessment is limited by and correlated to the volume of Medicaid services rendered compared to the total volume of all services rendered.

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g. Additional Disproportionate Share Payment -

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non- emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.